

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037077

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317Primary Registration District No. 541Registrar's No. 2559

FILED SEP 20 1962

1. PLACE OF DEATH

a. COUNTY

St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Clayton

Length of stay in 1b

1 day

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

St. Louis County Hospital

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

St. Louis

admission)

c. CITY
OR
TOWN

Jennings

Inside Limits

Yes ☒ No ☐d. STREET
ADDRESS

(If outside, give location)

5541 Jennings

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

WALTER

C.

Jones

4. DATE
OF
DEATH

Month

Day

Year

8

31

1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☒

8. DATE OF BIRTH

1/22/1892

9. AGE (last birthday)

72

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired General Work

10b. KIND OF BUSINESS OR INDUSTRY

Factory

11. BIRTHPLACE (City and state or country)

Union, Missouri

12. CITIZEN OF WHAT COUNTRY

U.S.

13a. FATHER'S NAME

William L. Jones Sr.

13b. MOTHER'S MAIDEN NAME

Hattie Ekey

14. NAME OF HUSBAND OR WIFE

Grace

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

Yes

16. SOCIAL SECURITY NO.

NN 1

17. INFORMANT

Address

Clarence Jones, 3042 Arlington Ave.

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Bronchogenic carcinoma, double pr

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 8-30-62 to 8-31-62 and last saw him alive on 8-31-62Death occurred at 5:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL CREMATION, OR OTHER DISPOSAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Albert H. Hoppe, Inc., 4700 Washington Blvd.

9-4-62

John B. Murphy, Jr.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

14002

24608

3

4 0

5 3

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9/62.1

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11

1245.0

13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melvin L. Kemper

Licensed Embalmer No. 4055

P. O. Address 4911 Washington
So. Fair, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.